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Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION MARCH 1982 ISSUE #3

MEDICAID MEDICARE EXCHANGE

Legislative Ledger

• S. 2142 was introduced to the Committee on Finance on February 25. This bill would amend the Social Security Act to provide for a new system of utilization and quality control peer review under the Medicare program. It would help redirect, simplify, and enhance cost effectiveness of the Professional Standard Review Organization (PSRO) under Medicare.

In addition, the bill promotes positive results of effective PSROs by entering into performance-based contracts with them. The use of Federal grants to support PSROs would be eliminated. PSROs as well as any other review entities utilized by Medicare would have to prove their effectiveness and value in the marketplace in order to continue their existence.

• On February 23, H.R. 5574 was brought forward to the Committee on Energy and Commerce. This bill would amend the Social Security Act to permit American Samoa to establish a Medicaid program.

For further information on these or other HCFA legislative issues, call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717. •

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NEW SYSTEM IS DEVELOPED TO IDENTIFY ABUSIVE PRACTICE PROBLEMS

Bureau of Quality Control's Office of Systems Analysis has developed the Ambulatory Care - Pattern Analysis System (AC-PAS). AC-PAS identifies ambulatory care providers whose patterns of practice are abusive, and ranks these providers so that limited investigatory resources can be applied in the most effective manner. AC-PAS basic approach involves patterns, an aberrant practice determination, and ranking.

Patterns - Those individual patterns indicative of a provider's total practice are analyzed. The information used is based on data in existing Medicaid and Medicare claims processing systems. The period analyzed is a minimum of 3 and a maximum of 12 months, based on the date of service. The patterns analyzed and ranked within peer groups are:

1. Average Dollars Per Patient - The sum of the allowed amount for all services rendered by each provider during the period is divided by the number of patients treated by the provider. Ranking determines which providers treat patients at a high average cost.

2. Average Services Per Patient - The sum of the number of services rendered by each provider during the period is divided by the number of patients treated by the provider. Ranking determines which providers perform an excessive number of services per patient.

3. Average Dollars Per Service - The sum of the allowed amount for all services rendered by each provider during the period is divided by the number of services furnished by the provider. Ranking determines which providers perform an excessive number of expensive services.

4. Yo-Yo - The sum of the total number of encounters each provider had with his/her patients during the specified period is divided by the provider's patients to derive each provider's average number of encounters per patient. Ranking determines which providers have an excessive number of encounters.

5. Gang Visits - The sum of the number of visits made to institutions by each provider during the period is divided by the number of days on which the provider made visits. Data is ranked to determine which providers bill for an excessive number of visits per day to patients in nursing/boarding homes.

6. Specified Services - Specific services are identified for each peer group and the percent of these services to all of the provider's services is computed. Data is ranked to determine which services constitute a high proportion of a provider's practice.

7. Specified Diagnoses - For each provider's claims which contain predefined diagnoses, the percent of the specified diagnoses to all of the provider's diagnoses is computed. Data is ranked to show whether a provider uses certain diagnoses too frequently.

8. Ping-Pong (Other Providers) - The average number of other providers the patients of the provider have seen is determined. Ranking determines whether a provider's patients see an excessive number of other providers.

Aberrant Practice Determination - For analysis purposes, the system treats each specialty as a separate peer group and the practice of each provider is compared only to his/her peer group (practicing specialty). The percent of providers whose practice is considered to be "normal" (e.g. 95%) is set by the analyst.

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CHICAGO PROGRAM OFFERS ALTERNATIVE TO INSTITUTIONALIZATION

A model long term home care demonstration project in Chicago is providing medical and social supportive services to chronically impaired homebound elderly. The Five Hospital Homebound Elderly Program gives the elderly access to services and supports necessary to remain in the community, thus avoiding unnecessary, inappropriate or premature institutionalization. This program is designed to provide comprehensive inhome services to each individual client. Each patient is assigned a nurse, social worker and home health aide who provide assistance needed to remain at home. Doctors from the participating hospitals make regular visits to the patients. The five hospitals participating in the program are: Augustana, Columbus, Grant, Illinois Masonic, and St. Joseph.

The program is operated by a hospital-linked but community-based home health agency which serves a population identified as being greatly underserved due to their physical inabilities to get to medical care. Most of the population served by this project do not qualify for the limited home health benefits provided under Medicare and Medicaid. Medicare home-care reimbursement is generally available only for those patients that are Medicare eligible and in need of intermittent skilled nursing or physical or speech therapy. In contrast, the program provides maintenance and respite care to chronically impaired patients age 83 and older. The program refers to these patients as the chronically impaired "old-old," meaning age 83 plus.

The program objectives are to: (1) provide comprehensive, coordinated medical and social supportive services primarily to the homebound elderly; (2) provide support and education to family, neighbors, and friends; (3) create new opportunities of employment and volunteer service for the older adult; (4) train health care personnel in the specialized needs and problems of the elderly; (5) demonstrate through careful program evaluation that a program like this one will reduce premature or inappropriate institutionalization and provide a community based, long term care alternative.

For further information regarding the program's services, contact Marvin S. Schreiber, Executive Director, Five Hospital Homebound Elderly Program, 600 West Diversey Parkway, Suite 200, Chicago, IL 60614, 312-549-5822. For information on its evaluation, contact Dr. Susan Hughes, Center for Health Services and Policy Research, Northwestern University, 629 Noyes Street, Evanston, IL 60201, 312-492-5109. ■

PERSPECTIVES' INDEX AVAILABLE

A complete index of articles and RADARs (Research and Demonstration Activity Reports) published since 1977 in Perspectives on Medicaid and Medicare Management and its predecessor, the Journal on Medicaid Management, is now available from the Institute. The index was slated for publication in a long delayed issue of Perspectives; however, it is being made available now as a reference tool.

In addition, some new Perspectives' annotated bibliographies are included in this issue on page 16.

Contact Ruth Perry, 301-594-8856, FTS 934-8856, for a copy of the index. ■

UPDATE OF ACTIVITIES OF THE 97TH CONGRESS

HCFA's Administrator has issued a report (No. 33 dated February 12, 1982) which highlights activities of the 97th Congress that relate to HCFA programs. Activities include 7,000 bills introduced, legislation passed, appropriations, and hearings held from January 5, 1981 to December 16, 1981. These are some of the activities mentioned in the report.

Bills Introduced

- H.R. 2508 (now H.R. 3399) and S. 1509 would give beneficiaries wider options in choosing providers, would contain health costs through increased use of more efficient delivery systems, and would stimulate competition. These bills would also provide for prospective reimbursement to health maintenance organizations (HMOs) at 95 percent of the average per capita Medicare cost, with any difference between the Medicare rate and the HMO's adjusted community rate applied toward additional benefits or reduced costs for Medicare enrollees.

- H.R. 4666 would use a voucher system to give Medicare beneficiaries the option of selecting either private health insurance coverage or enrollment in a prepaid health plan in lieu of Medicare benefits.

- S. 234 would expand Medicare home health services and require that home health services covered by Medicare must also be covered by Medicaid.

- S. 861 would establish six year demonstrations in ten States to test implementation of comprehensive community-based systems for providing long term care services to replace noninstitutional long term care services currently provided by Medicaid and Medicare. A similiar bill, H.R. 3355, was also introduced.

Legislation Passed

- The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) made several changes to the Medicaid and Medicare programs. It is estimated these changes will save about $35 billion in FY 82 spending. Savings from cuts in Medicaid and Medicare account for $2.3 billion of the amount. This law made adjustments in reimbursement policy, Medicare coinsurance and deductibles, the PSRO program, State flexibility in the Medicaid program, and Medicaid matching payments.

- P.L. 97-100 contained a provision that $5 million of Medicaid and Medicare payments for Indian Health Service (IHS) facility services be used to offset appropriations for Indian health services instead of for upgrading the facilities.

- P.L. 97-123 restored minimum benefits under the Social Security Act and requires that seven AFDC homemaker/home health aide demonstration contracts be signed by January 1, 1982. It also provided that, if necessary, the three Social Security trust funds (hospital insurance, disability, and old age and survivors) may borrow from each other to make mandated monthly benefit payments.

Appropriations

- H.R. 4560, Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Bill, provided that none of the funds appropriated in this bill can be used to implement or enforce provisions of the Omnibus Budget Reconciliation Act of 1981, specifically, those provisions regarding Medicare Part B and Medicaid reimbursement for less-than-effective drugs. The Senate

continued on next page

SOLICITATION FOR DEMONSTRATION PROJECTS PUBLISHED IN FEDERAL REGISTER

As mentioned in the January issue #2 MMX, HCFA anticipated issuing a special grant solicitation to States for demonstration projects that enhance competition among health insurers and providers of care by providing Medicaid beneficiaries the opportunity to select among alternative health plans. The solicitation appeared in the Federal Register on March 1, 1982; States have 60 days to respond.

The solicitation is issued under the authority of Section 1110 and Section 1115(a) of the Social Security Act. Section 1115 of the Act authorizes the Secretary of Health and Human Services to waive statutory Medicaid State plan requirements and to reimburse costs not otherwise Federally matchable in order to enable State agencies to carry out significant demonstration projects. The concepts to be demonstrated include:

- Vouchers - States offer vouchers to Medicaid recipients for the purchase of health insurance.
- Contracting with Private Insuring Organizations - Beneficiaries could obtain coverage from private insurance plans, as well as currently approved health care organizations, e.g., HMOs.
- Enrollment Incentives - States will be encouraged to test new marketing incentives such as guaranteed eligibility, cash rebates, and additional benefits covered through cost savings.
- Role of Broker - States will determine whether marketing is most effectively implemented through a broker, by the State, or by individual providers.
- Freedom of Choice - States would be permitted to competitively determine the most cost effective provider plan in an area, and then assign Medicaid eligibles to that plan.

In fiscal year 1982, HCFA anticipates awarding a total of $1.5 million for administrative costs associated with the competition demonstrations. Call Eric Nevins, 301-594-1962, FTS 934-1962, for further information.

97th Congress - continued from page 4

modified House language on less-than-effective drugs and added new language to allow the Federal government to continue to provide 100 percent Medicaid reimbursement for services in IHS facilities.

- P.L. 97-12, Supplemental Appropriations and Rescission Act of 1981, rescinded funds for two HCFA activities: $9 million for research and evaluation, and $29 million for PSROs.

Hearings Held

- Some hearings addressed a wide range of health-related budget proposals; others concentrated on one proposal such as the Medicaid cap.
- Several meetings dealt with budget proposals in health, Social Security, social services and public assistance programs.
- Several hearings addressed proposed budget cuts in the Medicaid and Medicare programs and the phase-out of the PSRO program. Hearings discussing questions of budget cuts for child health and the elderly and minority elderly were also held.

COMPUTER MATCHING STUDIES DISCOVER MILLIONS IN MEDICARE OVERPAYMENTS

Bureau of Quality Control's Office of Financial Analysis has been conducting a series of computer matching studies. These studies indicate millions of dollars in overpayments are made to Medicare beneficiaries who are also eligible for payment of medical expenses by the Department of Labor's black lung program.

Medicare is prohibited by law from paying for medical services covered by the black lung program. Last year, onsite financial analyses in three intermediaries demonstrated that current Medicare procedures for preventing erroneous payment are inadequate and result in millions of dollars in overpayments. Those findings are now being confirmed by the computer matching studies of Medicare payments to hospitals for black lung beneficiaries.

One computer matching study identified six hospitals in Kentucky that had large numbers of Medicare bills covering services for which the Department of Labor should pay. The Office of Program Validation in HCFA's Atlanta regional office conducted a review of the medical records for the 116 stays involved. Preliminary results indicate over $125,000 in overpayments.

In a related computer matching study, potential duplicate payments totalling about $200,000 have been identified in West Virginia, Kentucky, Ohio, Pennsylvania, Virginia, Tennessee, and Illinois. One 38 bed hospital has been averaging one potential duplicate payment a month.

HCFA is developing systematic means to reduce the problem of overpayments and duplicate payments for persons eligible for both black lung and Medicare benefits. Eventually the responses to contractor eligibility queries will include a trailer code showing the beneficiary's black lung eligibility. When the contractor receives the trailer code, it will be able to check the diagnoses and procedures on the Medicare bill to assess the potential for black lung program liability.

Budget and staffing limits have delayed full implementation of the necessary policy and systems changes. Pending implementation, State listings of black lung/Medicare dual eligibles will be available to regional offices, contractors, and/or State agencies wishing to evaluate their experience or to implement procedures for preventing overpayments and duplicate payments. For more details, call Larry Davidoff at 301-597-1371, FTS 987-1371. ■

MMMI EVENTS

State Medicaid Directors' Annual Conference
April 26-29 Salt Lake City, UT

Contact: Edward Palder
301-594-8940
FTS 934-8940

Carrier Representative Group (CRG) Meeting
May 5 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

Health Care Financing R&D Reports

This column lists research, demonstration, and statistical data published by HCFA's Office of Research and Demonstrations (ORD).

Research Reports

Listed by title are final research reports available from:

HCFA, Office of Research and Demonstrations
1-E-9 Oak Meadows Building
6325 Security Boulevard
Baltimore, MD 21207
301-597-2422, FTS 987-2422

Health Care Financing Review - December 1981 - HCFA Pub. No. 03139

- Health Insurance and Health Policy in the Federal Republic of Germany
- The Nursing Home Population: Different Perspectives and Implications for Policy
- Regional Hospital Input Price Indexes
- The Use of Intensive Care: A Comparison of a University and Community Hospital
- Copayments and Consumer Search: Increasing Competition in Medicare and Other Insured Medical Markets

Statistical Reports

There were no additional statistical reports published since those listed in MMX issue #1 dated November 1981.

Other Reports

Following is a listing of final reports that can be purchased from:

National Technical Information Services
Document Sales
5285 Port Royal Road
Springfield, VA 22151
703-487-4650

- Medicaid Nursing Home Reimbursement in Louisiana -- PB82 139932
- Medicare Impact on Hospital Utilization and Financing -- PB82 157405
- The National Child Day Care Association EPSDT Demonstration Project (Evaluation Report) -- HRP 0903088
- Assessment of Cost and Operational Impact of SNF/ICF Standards (Vol. I Executive Summary) -- PB 259022
- Assessment of Cost and Operational Impact of SNF/ICF Standards (Vol. II) -- PB 259023
- Medicare and Medicaid Contracting (Vol. I) (Recommendation) -- HRP 0029401
- Medicare and Medicaid Contracting (Vol. II) (Issue Papers) -- HRP 0029402
- Contra Costa County California EPSDT Demonstration 1973-1977 -- HRP 0903151
- Excess Hospital Capacity Study (Final Report) -- PB82 159062

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact person listed with each regulation.

Medicare Program: Premium Rate for the Uninsured Aged - General Notice
12/31/81 Federal Register
Contact: Guy King, 301-594-2826, FTS 934-2826

Monthly Actuarial Rate and Monthly Premium Rate - General Notice
12/31/81 Federal Register
Contact: Joseph Romano, 301-594-1023, FTS 934-1023

Medicaid and Medicare Programs: Less Than Effective Drugs - Notice of Legislation Affecting Implementation and Enforcement of Interim Final Rule
01/13/82 Federal Register
Contact: Henry Hehir, 301-594-8561, FTS 934-8561

Medicaid Program: Hearing; Reconsideration of Disapproval of Alabama State Plan Amendments Requiring Copayments for Drugs for Certain Categorically Needy Groups - Notice of Hearing
01/22/82 Federal Register
Contact: Stanley Krostar, 301-594-8511, FTS 934-8511

Medicaid Program: Hearing; Reconsideration of Disapproval of Minnesota State Plan Amendments - Notice of Hearing
02/03/82 Federal Register
Contact: Lawrence Ageloff, 301-594-8260, FTS 934-8260

Medicare Program: Medicare Payment Where Beneficiary is Not at Fault - Proposed Rule
02/04/82 Federal Register
Contact: Jack Wasserman, 301-594-9300, FTS 934-9300

Medicaid Program: Reconsideration of Disapproval of Rhode Island State Plan Amendments; Hearing - Notice of Hearing
02/08/82 Federal Register
Contact: Albert Miller, 301-597-2896, FTS 987-2896

Medicare Program: End-Stage Renal Disease Program; Prospective Reimbursement for Dialysis Services - Proposed Rule
02/12/82 Federal Register
Contact: Bernadette Schumaker, 301-597-1048, FTS 987-1048

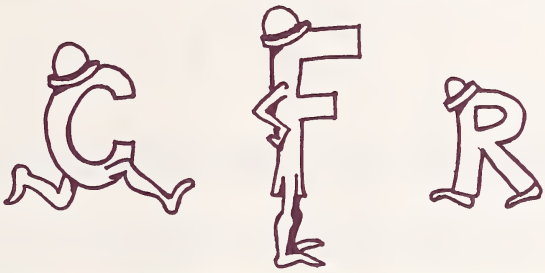
Medicaid Program: Hearing; Reconsideration of Disapproval of Indiana State Plan Amendment Requiring Continuous Deeming of Income in Certain Cases Involving Institutionalized Individuals - Notice of Hearing
02/12/82 Federal Register
Contact: Stanley Krostar, 301-594-8511, FTS 934-8511

REVIEW

Medicaid Program: Hearing; Reconsideration of Disapproval of Iowa State Plan Amendment - Notice of Hearing
02/12/82 Federal Register
Contact: Albert Miller, 301-597-2896, FTS 987-2896

Medicaid Program: Hearing; Reconsideration of Disapproval of a Massachusetts State Plan Amendment - Notice of Hearing
02/12/82 Federal Register
Contact: Stanley Krostar, 301-594-8511, FTS 934-8511

Medicare Program: Reduction in the Number of Providers Dealing Directly with HCFA - Notice of Proposed Rulemaking
02/18/82 Federal Register
Contact: Norman Fairhurst, 301-594-9498, FTS 934-9498



UPDATE OF THE NEW STATE MEDICAID MANUAL

The August/September MMX issue announced that the new State Medicaid Manual (SMM) would completely replace the Medical Assistance Manual (MAM) by Spring 1982. The SMM was to be phased in one part at a time until the MAM was completely replaced. However, due to the many changes in the Medicaid program because of the 1981 Omnibus Budget Reconciliation Act, completion of the SMM project has been postponed until all the Medicaid regulations implementing the Act have been promulgated.

Several SMM issuances have been distributed. Medicaid materials for State agencies will continue to be provided as SMM issuances, Action Transmittals, or Information Memorandums, as appropriate.

ACTION TRANSMITTALS

These Action Transmittals were issued by HCFA in January 1982.

AT-82-01 Continuing Medicaid Eligibility for Certain Recipients of Veterans Administration Pensions (Refer to: Section 310 of Public Law 96-272)

AT-82-02 Rescission of Medicaid Action Transmittal 80-56 (Effective January 1982)

AT-82-03 Title XIX, Social Security Act: Repeal of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Penalty (Refer to: Section 2181 of Public Law 97-35, enacted August 13, 1981, and effective October 1, 1981, added new Section 1902 (a)(44) of the Act)

INFORMATION MEMORANDUMS

The following Information Memorandum was published in December 1981, and is the only one published since those listed in MMX issue #1.

IM-81-14 Inviting States to Submit for Pilot Testing of New Subsystems for the Medicaid Management Information System (MMIS) - INFORMATION

Personnel

MEDICAID

Medical Assistance Unit Directors

Henry C. Vaughn, Jr. - Acting Commissioner, Alabama Medical Services Administration

HCFA

Central Office

Bryan Luce, Ph.D. - Director, Office of Research and Demonstrations

CONSULTATIVE ACTIVITIES

RESULTS OF FEBRUARY 3 CARRIER REPRESENTATIVE GROUP (CRG) MEETING

A CRG meeting was held on February 3, 1982. Dr. Carolyne Davis, HCFA Administrator, presented the opening remarks. The meeting's major agenda items included: carrier budget issues; the Cost/Burden Reduction Task Force initiative; and, benefit/cost implications of the current environment.

The Administrator discussed the current budgetary constraints and their impact on HCFA staffing and organizational structure. The major cost reduction initiatives being undertaken were part of the discussion on the Cost/Burden Reduction Task Force initiative.

Also reviewed at the meeting were the carrier performance standards that are in need of review due to operational reductions and abatements. The carrier performance standards were reviewed and modified at a technical advisory group meeting held on February 23-25.

The next CRG meeting is scheduled for May 5, in Baltimore. Contact: Paul Beller, 301-594-9455, FTS 934-9455. ■

SUMMARY OF RECENT STATE MEDICAID GROUP (SMG) MEETING

On February 9, SMG members met with HCFA staff to discuss the Administration's proposal for Federalizing Medicaid. The participants discussed the impact the Administration's proposal would have on State Medicaid programs. SMG members made known to HCFA their concerns that should be considered.

Views were also exchanged on the FY 83 budget, selected sections of the Omnibus Budget Reconciliation Act of 1981, and status of HCFA's deregulation effort. In addition, SMG members were asked to help HCFA identify priorities regarding conference/workshop and TAG (technical advisory group) meetings. In view of current budget constraints, they were also asked to recommend ways to reduce costs of future TAG meetings.

M/MMI prepared and distributed to SMG members a paper that updated TAG activities. Contact: Edward Palder, 301-594-8940, FTS 934-8940. ■

RECAP OF RECENT FISCAL INTERMEDIARY GROUP (FIG) MEETING

At the FIG meeting held on March 10, HCFA's Administrator spoke of current program issues. Other major discussions at this meeting covered contractor budget issues, the Medicare administrative reform initiative, revision of the contractor performance evaluation program, and home health agency issues.

The Administrator also noted the challenging period for Medicare administration. She reviewed the initiatives being undertaken to reduce the contractors' budgetary burdens, the reduction and streamlining of regulations, as well as the implementation of legislative proposals. Contact: Paul Beller, 301-594-9455, FTS 934-9455. ■

NEWLY FORMED HCFA TASK FORCE REVIEWS PUBLICATIONS

HCFA's Administrator has established a HCFA Publications Task Force. The Task Force will analyze the need for HCFA publications, their costs, and effectiveness so that decisions can be made concerning their futures.

The Task Force held its first meeting on February 26. Members discussed clearance requirements under the EOMB moratorium, and the review process for periodicals, recurring publications, and single issuances.

At this meeting, the Task Force specifically reviewed the HCFA Review, Trend, M/MMI's Perspectives on Medicaid and Medicare Management, and the Medicaid Medicare Exchange newsletter.

Charlene McCants, Associate Administrator for External Affairs is the chairperson for this task force. Other members include: Richard Teske, Steve Pelovitz, Kevin Sexton, Tera Younger, and Larry Oday.

Future meetings will be scheduled. For more information, call Adrian Sybor from HCFA's Office of Public Affairs at 301-594-9560, FTS 934-9560, or 202-245-8056. ■

OBS HOLDS CONFERENCE TO IMPROVE SERVICES TO BENEFICIARIES

The Office of Beneficiary Services (OBS) has three primary objectives: to better inform beneficiaries about HCFA programs and their rights and responsibilities; to open channels of communication between beneficiary representative groups and HCFA; and, to improve services to beneficiaries through the HCFA network including contractors, State agencies and Social Security offices.

In order to strengthen the effectiveness of beneficiary services' activities, OBS conducted a two-day conference for HCFA regional office staff on March 2-3. One day was devoted to a review of the National Medigap Training Program, including plans for the implementation of the Voluntary Certification Program, and a consideration of recommendations for further improvements in the administration of HCFA's continuing nationwide Medigap information and education effort. The second session concentrated on regional/central office activities with the objective of identifying mutually supportive roles and determining the continuing conduct of beneficiary services' activities. Contact: Elaine Gutman, 301-597-2898, FTS 987-2898. ●

Department of Health and Human Services
Richard S. Schweiker, Secretary

Health Care Financing Administration
Carolyne K. Davis, Ph.D., Administrator
George A. Thompson, Associate Administrator
for Operations

Bureau of Program Operations
Tera S. Younger, Director

Medicaid/Medicare Management Institute
Will Wolstein, Acting Director

Editor: Joan F. Kahl
Graphics: Mary Lou Hutchison

LITIGATION IN BRIEF

Following are recent reimbursement, coverage, and/or eligibility court decisions in civil litigation involving the Medicaid and Medicare programs. Call John Bader of HCFA's Civil Litigation Branch on 301-594-9708, FTS 934-9708, for further information about these cases and about judicial developments concerning Medicaid and Medicare in general.

Alternative Hospital Medicaid Payment Plan Passes Court Test

The Georgia Hospital Association challenged the Secretary's approval of the State Medicaid agency's hospital reimbursement demonstration project. The project was designed to control hospital costs by placing hospitals in groups based on similarity of cases treated, with a maximum set limit of Medicaid reimbursement per patient.

The plaintiffs claimed that the project was unconstitutional because it reduced hospital reimbursement, was subject to change without notice, and was too complex and subjective. The court found that the providers had no constitutional property interest in continued Medicaid reimbursement and no constitutional right to reasonable cost reimbursement. The court also concluded that the claims regarding change without notice, complexity, and subjectivity were speculative and unpersuasive.

Appeals Court Assumes Jurisdiction in State Plan Dispute

The U.S. Court of Appeals for the Third Circuit assumed jurisdiction over New Jersey's State Medicaid plan dispute, following a hearing before a Grant Appeals Board. Section 1116(a) of the Social Security Act authorizes direct appeals to a Court of Appeals where a State is dissatisfied with the Secretary's refusal to approve its Medicaid plan or an amendment thereto. Where the Secretary makes no such finding, but simply disallows a State's request for reimbursement, a petition to the Court of Appeals is not in order.

Before New Jersey entered the Medicaid program, they had a medical assistance program for indigent aged (MAA) residents, which included institutionalized aged residents unable to qualify for Old Age Assistance (OAA) because of excess income and resources. After adoption of the Medicaid program, former MAA recipients who qualified for OAA payments were included in the categorically needy program. However, since the State did not elect to cover the medically needy, former MAA recipients who were ineligible for OAA were excluded from program participation. The State subsequently attempted to include this group by creating an optional category, and subsequently sought retroactive reimbursement.

The Court of Appeals found jurisdiction by ruling that this is a case of overall noncompliance, and thus falls within the requirements for appeals court review. The court then ruled that New Jersey was not entitled to the retroactive reimbursement it sought, since under the Medicaid Act only individuals who

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Litigation in Brief - continued from page 14

received actual money grants could qualify for the categorically needy treatment.

Interest Income/Expense

A Federal district court has held that interest paid by the Internal Revenue Service (IRS) to a provider for taxes erroneously paid and now refunded cannot be treated as "investment income" by the Medicare program.

For several years, four Minnesota providers, including Abbott Northwestern Hospital, erroneously paid Social Security taxes to IRS for the wages of their employees. Once the mistake was discovered, IRS refunded the payments with interest. The intermediary treated the interest as though it were investment income under 42 CFR Section 405.419, and used it to reduce allowable interest expense. The Provider Reimbursement Review Board and HCFA's Administrator agreed with the intermediary's action.

The court found, however, that erroneous payments to the IRS could not be considered investments under the regulation. The regulation specifically requires offsetting only investment income.

No decision has yet been made on whether to appeal.

Earnings for Trustee-Held Fund

A hospital could not escape the requirement that interest income must be offset against interest expense on the ground that income earned by a trustee-held fund was not its income, the U.S. District Court in New Hampshire has concluded in the Cheshire Hospital case.

The fund in question was a debt service reserve fund. This type of fund is used to pay the principal and interest on bonds issued to construct a new facility if there are deficiencies in other funds from which such payments are to be made. The provider pointed out that it had no control over this fund, therefore, the income should not be considered its income.

The court noted, however, that the fund benefited the provider since it complied with the lender's requirements and protected the bondholders. The court also pointed out that any surplus earnings would inure to the benefit of the provider. ■

M/MMI CONDUCTS THREE MEDICAID WORKSHOPS

M/MMI in cooperation with staff from the D.C. Medicaid program developed a successful three day Medicaid orientation workshop. Three workshops were held during February and March. The topics covered included: program administration, Medicaid eligibility standards, program benefits, reimbursement methodologies, Federal Financial Participation, and the Medicaid Management Information System (MMIS).

For more information on the workshops, contact Annie Phillips, D.C. Office of Health Care Financing, Department of Human Services, at 202-727-0753. ■

annotated bibliography

Mahler, Julianne, "Barriers to Coordinating Health Services Regulatory Programs," Journal of Health Politics, Policy and Law, Vol. 6, No. 3, Fall 1981, pages 528-541.

The author provides an excellent commentary about the difficulties encountered when attempts are made to coordinate Federal and State regulatory programs. She states that although these programs have "mushroomed" in response to a perceived need, they present serious problems to peaceful coexistence by creating piecemeal, ill-planned interaction. Ms. Mahler expounds on the various barriers to coordination by examining two programs considered key cost containment strategies: prospective rate review and certificate-of-need (CON) review.

Prospective rate review is a form of price regulation which determines the reasonableness of a health care facility's cost. CON review is a regulatory process which determines the need for new hospital facilities or costly capital improvements. Prospective rate review is sponsored by both Blue Cross and State governments, whereas CON review is authorized by State statute and Federal guidelines. The author believes these two programs to be particularly interdependent, and gives four approaches to coordinating CON and prospective rate review programs.

The first and most common approach, she advises, is to have the rate or budget review staff perform the financial feasibility analysis portion of CON reviews. Among other benefits, this allows comparison of the long term cost effects of rival proposals. A second approach requires rate reviewers to approve hospital requests for higher costs or charges for capital improvements which have been approved under CON. She assures that this helps enforce CON decisions and avoids the possibility of conflicting findings between the programs. However, the reader is advised that this approach may place CON reviewers in the position of having to decide which hospitals will be allowed higher costs or charges. The third approach advocated is for States to include consideration of need in rate review. Ms. Mahler believes it to be a way of linking the two regulatory programs to encourage the efficient use of hospital facilities. Her fourth approach is to physically locate the two programs within the same agency. She admits that this form of organization may do little to integrate procedures and findings, but thinks it is a step toward program coordination. She suggests that all these approaches may have some use provided that certain impediments are overcome.

She explores these impediments by categorizing them as three barriers: technical, administrative and political. Problems encountered in the development of criteria and procedures are called technical barriers. They generally include the lack of proper facilities, staff, financing arrangements, and poor program planning to fit the medical needs of the target population. To overcome such difficulties, she believes, requires joint advance planning as well as continual feedback. Administrative barriers

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come into focus when programs are administered under different agencies. The placement of both programs under a single administrative umbrella is offered as a possible route around this barrier. Ms. Mahler states that "political barriers constitute the ultimate impediment to coordination, because devisive political interests can retard progress toward resolving technical and administrative problems." She does not give a solution for this. Rather, she cites three groups maintained by the health care industry, they are: 1) the physicians, 2) the health care institutions, and 3) various advocacy groups.

Although these programs exist because of a perceived need, the author states that they may not be the best routes to cost containment. Though relatively far off on the horizon, alternatives are appearing. The author believes that dissatisfaction with the present situation and increasing criticism concerning the quality of health care may provide the kind of environment necessary to overcome the present fragmented approach of governmental programs.

Johnson, Donald E., "Quality Circles Put Workers in Charge of Their Productivity," Modern Healthcare, September 1981, pages 68-74.

Mount Sinai Medical Center of Greater Miami, Miami Beach, Florida, is implementing a new concept in management. The hospital's executive vice president and chief executive officer, Alvin Goldberg, is an advocate of participative management. In essence, this concept means that workers participate with managers in problem-solving responsibilities, as well as decision making processes. The author reports that Mr. Goldberg has chosen to implement the concept by creating "quality circles" or hospital departmental committees. Although participative management is relatively new in American industry, Mr. Johnson says that Japanese companies have successfully utilized quality circles for some 20 years. Mount Sinai is the first such industry to utilize quality circles. About 200 other hospitals are reported to have inquired about the program's progress.

The author says that Mr. Goldberg believes that the implementation and operation of quality circles will do much to improve quality and productivity, in addition to reducing the drain of staffing resources. Several examples of progress are cited. One deals with the dietary workers. The problem was that the wrong food went to patients ordering items not on the hospital's printed menus. The dietary quality circle found that the clerks gave a higher priority to meeting a 3 p.m. deadline for getting orders to the kitchen. To resolve this problem, the quality circle recommended extending the deadline to 4 p.m. The author states that Mr. Goldberg recalled that "their new project is reducing errors in charting menus."

Although there is a degree of success, it is reported that the program is not without some hazards. Among the hazards are the physicians' and department heads' perceptions of it. However, it is believed that as soon as everyone understands that each has an important role to play in the program, this management approach could pay big dividends.

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Annotated Bibliography - continued from page 17

Ruchlin, Hirsch S., Ph.D.; Hamer, Robert, B.S.; and, Braham, Robert L., M.D., "Cost of Hospital Care and Third Party Payor Reimbursement," New York State Journal of Medicine, March 1981, Bulletin 260, #6, pages 411-415.

This article focuses on selected aspects of hospital economics. The authors explore and comment upon the interrelationships of three key concepts of hospital economics: charges, reimbursement, and actual cost. They explain that cost containment has become focused on the hospital sector because hospital care accounts for the largest share of national health care expenditures, 40 percent of the total, and hospitals represent the largest concentration of producers and distributors of medical care. The authors report one theory that holds that if hospitals reduce their costs, their expenditures will decrease. They point out that most cost containment initiatives are presented at the State level.

To assist the readers in understanding the differences between patient charges, reimbursement revenue received, and actual cost of care rendered, the authors examine the cases of two patients recently admitted to "The Hospital" in New York. The two cases selected represent a relatively complicated and a simple admission. Using these two illustrative cases, they test their concepts and examine their interrelationships.

An analysis of the charges for those two patients indicated that there was no direct relationship between volume and prices of services provided to these and other patients, and the reimbursement hospitals received from private insurance, Medicare, or Medicaid. The authors emphasize that all charges were not covered by third party payors. Reimbursement from third party payors did not include non-covered charges. Therefore, "The Hospital" must try to collect charges for non-covered services from the patient. If the patient refuses to pay this debt, "The Hospital" must assume the loss. Third party payors in New York do not pay charges, rather, they pay a per diem reimbursement rate. The authors agree that there was no direct relationship between the type and volume of services provided and the percent of charges reimbursed by third party payors. The authors point out that government regulations stipulate that a hospital be paid the lower of charges or cost. Therefore, the difference represents a loss to the hospital. This causes hospitals to set charges higher than costs. Various tables in the article illustrate patient charges, inpatient costs, per diem cost, estimated gains and losses per case and a comparison of expense factors used by reimbursement agencies with projected hospital data.

The authors also review third party rate setting for the two cases studied. They suggest that third party per diem reimbursement, by design, failed to cover true costs. They explain the methods used by Blue Cross/Blue Shield in New York and by Medicaid in establishing their rates; a different method is used by Medicare. The authors pointed out that while the per diem rate received by "The Hospital" from Blue Cross/Blue Shield, Medicare, and Medicaid patients differ, there was no consistent pattern in the ranking of these rates.

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Thompson, Robert R., M.D., "I Gave Up Medicaid - But Not My Needy Patients," Medical Economics, October 12, 1981, pages 133-139.

The author, a Minnesota family practitioner, candidly describes his views and reasons for deciding to refuse to accept Minnesota Medical Assistance (MA) (Medicaid) payments for his patients. Some of the problems Dr. Thompson had with MA payments before he changed his system were: he always had a stack of pink Medicaid computer forms that were in various processing stages; much of his office staff meetings were tied up in learning how the Medicaid reimbursement system worked; frequently he could not see a patient with an acute or urgent (not emergency) problem since he was seeing two or three Medicaid patients with minor complaints; and, many times Medicaid did not reimburse for the complete cost of care.

After making his decision to give up Medicaid, Dr. Thompson told most of his Medicaid patients that he would no longer accept MA payments. Dr. Thompson also put a sign in his office, and sent letters to all his Medicaid patients informing them of his new billing system. Dr. Thompson offered his Medicaid patients three payment alternatives, they could: transfer to another physician that accepts Medicaid payments; continue seeing him and make small monthly payments without interest; or, exchange service or commodity for his services.

About half of Dr. Thompson's Medicaid families agreed to stay in his practice. The author states that since implementing his new payment system, his practice has continued to expand, he no longer has a stack of pink Medicaid forms, and his accounts receivables have come down. "For all these patients I may not be collecting much more than I would have through Medicaid, but I feel a lot better about giving them service. The question is not whether we should take care of the poor, but how it should be done."

Loeser, William D., Dickstein, Emil S., M.D., Gilchrist, Valerie J., M.D., Weiss, Gary, "Federal Regulation of Medical Practice in Nursing Homes," Forum on Medicine, August 1980, pages 512-515.

The authors of this article are: a nursing home medical director (Loeser), who is also an assistant professor of medicine at an Ohio medical school; the administrator (Weiss) of the same Ohio nursing home; and a clinical assistant professor (Dickstein), who, with another author (Gilchrist), is a member of a department of family practice for an Ohio hospital association. They discuss the numerous rules and regulations, and their frequent revisions, which are produced by various Federal agencies and affect nursing home management and the physicians serving nursing home patients.

The authors conclude that despite the conflicts, incongruities, and confusion of government regulations and policies associated with nursing homes, some order can be established. They have, therefore, developed guidelines for physicians who care for nursing home patients. Subjects include: patient care policies, duties of a medical director, required nursing home committees, Medicare certification and recertification, and utilization review. They recommend containment of government agencies which produce nursing home regulations to "leave a little of the art and humanity of medicine - and time - for the care of patients."

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Sapienza, Alice M., "Managing the Ambulatory Facility: Setting Up the Information System," Journal of Ambulatory Care Management, November 1980, pages 57-63.

The author, Assistant Director of Boston's Beth Israel Hospital, discusses what is involved when an information system is set up for an ambulatory facility. She explains how to secure the data a manager would need for an information system. In an information system, internal operations data are evaluated in connection with external environment data. Ms. Sapienza mentions that in this kind of approach, information systems should be geared to the type of health care an ambulatory facility delivers.

The ambulatory care facility has at least two functions, patient care and administration. Information needed on patient care is described in detail by its volume, utilization, vital statistics, patient origin, visit levels, and costs and revenues. Data for administration support costs include the expenses of staff salaries and supply equipment. If the facility also maintains teaching and research functions, the manager must know the proportions of staff time spent in each activity, the corresponding costs, and supporting revenues.

The author believes the most difficult step for setting up an information system is finding appropriate sources for data collection. "The approach to the issue of management information is from the inside out: internal data on operations (cost, utilization, and consumers) evaluated in the context of external data on the environment (population characteristics, similar facility operations, and national policies)." The manager of an ambulatory facility must know in detail how the facility operates and how it will be influenced by future events. Being able to forecast future activities is a management responsibility, and by having an information system, a manager can easily complete this duty. ■

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The system then uses actual data to determine the "normal" range for each pattern for each peer group. The provider's practice is deemed to be aberrant if he/she exceeds the "normal" range for the peer group for any one pattern. Relative ranking helps determine if further investigation is needed and/or cost effective.

Ranking - Two factors are considered for ranking: the extent (in dollars) to which the provider exceeds the highest "normal" provider in the peer group in terms of average dollars allowed per patient; and, the number of patients treated by the provider. These factors are multiplied and the composite score is a measure of the additional dollar amount allowed for services rendered by the provider over that which would be allowed to the highest "normal" provider in the peer group for the same number of patients.

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